STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155778	A. BUILDING 01 B. WING _____	01/31/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR NURSING CENTER	1212 E MAIN ATTICA, IN 47918

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		

A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).

Survey Date: 01/31/11

Facility Number: 000323
Provider Number: 155778
AIM Number: 100288440

Surveyor: Bridget Brown, Life Safety Code Specialist

At this Life Safety Code survey, Woodland Manor Nursing Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.

This one story facility was determined to be of Type III (211) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and resident rooms. The facility has a capacity for 52 and had a census of 49 at the time of this survey.

Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on [illegible]

APPROVED
3/11/11 BB

The facility was found not in compliance with the aforementioned requirements as evidenced by:

K 021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 021	

RECEIVED

FEB 17 2011

LONG TERM CARE DIVISION
INDIANA STATE DEPARTMENT OF HEALTH

K021Corrective Action

A magnetic holder shall be installed on the self-closing corridor access door to the shower room.

Other Deficient Practice Identified

The maintenance director and HFA shall examine the facility for any other self-closing doors being prevented from closing. All staff

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kay Plunkett HFA	Administrator	2/16/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

ENTERED FEB 18 2011

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K 021	Continued From page 1 Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure access doors to 1 of 5 hazardous areas such as a storage room for the collection of soiled linens and trash was held open only with a device which allowed the door to close automatically. This deficient practice affects visitors, staff and more than 4 residents in the B smoke compartment. Findings include: Based on observation with the maintenance director on 01/31/11 at 1:05 p.m., the self closing corridor access door to the shower room used for the collection of soiled linen and trash receptacles was prevented from closing by a plastic hanger wedged under the open door. The maintenance	K 021	shall be in-serviced on the importance of not blocking or stopping self-closing doors. **Systemic Change** The maintenance director shall conduct monthly fire drills at which time closure of corridor access door to shower room will be monitored to ensure proper closure. **Monitoring** The maintenance director shall report any noted malfunction or blocking of self-closing doors to the Quality Assurance Committee. The QA Committee shall review and provide suggestions if necessary. **Date of Completion** All corrections shall be completed by March 2, 2011	

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K 021	Continued From page 2 director said at the time of observation, the door should not have been held open. 3.1-19(b)	K 021	**K025 Corrective Actions** All penetrations will be filled with an approved fire resistant material-Fire Barrier Sealant.	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure openings through smoke barriers in 3 of 6 smoke compartments were protected to maintain the smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient could affect visitors, staff and 4 or more residents in the A, B and F smoke compartments which include the main dining room. Findings include:	K 025	**Other Deficient Practice Identified** The maintenance director and HFA shall examine the facility for any other penetration that may be filled with an unapproved material. If any other penetration noted, the penetration shall be repaired with an approved fire resistant material-Fire Barrier Sealant. **Systemic Changes** The maintenance director shall conduct quarterly visual audits, examining for any penetration. Any penetration noted shall be repaired with a fire barrier sealant. Quarterly audits will ensure deficient practice does not recur. **Monitoring** The maintenance director shall report any noted penetration to the Quality Assurance Committee and the repair completed. The QA Committee shall review the report and provide suggestions if necessary.	

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K 025	Continued From page 3 Based on observation with the maintenance director on 01/31/11 between 10:20 a.m. and 1:20 p.m., the following had unsealed penetrations of the smoke barriers or penetrations sealed with a foam product without a fire rating: a. A sprinkler pipe penetration in the corridor wall shared with the nurses' lounge was unsealed leaving an annular gap of 1/2 inch; b. Two sprinkler pipes penetrating the corridor wall shared with the director of nurses office were unsealed leaving annular gaps of 1/2 and one inch; c. The two inch gap in the wall of a storage room near A101 was filled with an expandable foam which was not fire rated; d. An unsealed sprinkler pipe penetration in the brief storage room wall left a half inch annular gap; e. A four inch hole in the electrical room/maintenance area was sealed with an expandable foam which was not fire rated; f. The annular gap around a pipe penetrating the wall of the clean laundry room was filled with an expandable foam which was not fire rated; g. A one inch hole in the kitchen storage room ceiling above the compressor was unsealed. h. One half inch gaps around two unsealed penetrations by a bundle of black cable and conduit in the smoke barrier wall above the ceiling near room D121. The maintenance director agreed at the times of observation, the gaps should have been sealed with a fire rated material. 3.1-19(b)	K 025	**Date of Completion** All corrections will be completed by March 2, 2011	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	K 029	**K029 Corrective Action** 1. The 24x24 inch opening between the clean and soiled utility closed with dry wall. Self-closure placed on activitie's office door.	

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K 029	Continued From page 4 fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: 1. Based on observation and interview, the facility failed to ensure 2 of 5 hazardous areas, such a soiled linen and trash receptacle storage room and combustible storage rooms larger than 50 square feet in size, were equipped with self closing doors. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and more than four residents in the B smoke compartment housing the nurses station. Findings include: Based on observation with the maintenance director on 01/31/11 at 12:30 p.m., a 24 by 24 inch opening existed in the wall between the the clean utility room and soiled utility room which was used for the collection of six soiled linen and trash receptacles filled to various levels. The clean utility room corridor access door was not equipped with a self closing device. The maintenance supervisor said at the time of	K 029	2. a. The 8x10 inch vent opening-vent removed and area closed with dry wall. b. The twenty-four inch door will have self-closing hinges and magnetic holder installed. c. The four-foot by five-foot food service window will have self-closing door with magnetic holder installed. **Other Deficient Practices Identified** The maintenance director and HFA shall examine facility for any other opening. If any other opening noted, the opening shall be closed. **Systemic Changes** The maintenance director shall conduct quarterly visual audits examining for any other opening. Any openings noted shall be closed. Quarterly audits will ensure deficient practice does not recur. **Monitoring** Maintenance director shall report any openings to Quality Assurance Committee. QA committee shall	

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K 029	Continued From page 5 observation, he didn't realize the opening between the rooms left the hazardous soiled utility room without protection of a self closing door. Based on observation with the maintenance director on 01/31/11 at 12:10 p.m., a nine by ten foot activities office was used for the storage of combustible activities decorations, and materials made of cardboard and plastic. The maintenance director said at the time of observation, he didn't know a storage room larger than 50 square feet required a door with a self closer. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 5 hazardous areas, such as the kitchen, was separated from other spaces by a smoke resistant partitions. This practice affects visitors, staff and an undetermined number of residents in the F wing where the main dining room is located. Findings include: Based on observation with the maintenance director on 01/31/11 between 10:30 a.m. and 11:00 a.m., the following corridor wall openings were determined to be hazardous areas: a. The eight by twelve inch vent opening in the lower half of the corridor wall opening into the kitchen storage room. The maintenance director said the opening was to provide ventilation for an air compressor in the storage room. b. The twenty four inch square opening into the kitchen dish washing room, which had a door to close manually over the opening in the event of fire. The maintenance director said at the time of observation, "the opening had been there	K 029	review and provide suggestions if needed. **Completion** All repairs will be completed by March 2, 2011	

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K 029	Continued From page 6 forever". c. The four by five foot kitchen food service window in the corridor wall. The opening had a wooden door which slid on a track mounted to the exterior of the kitchen wall which would be closed manually in the event of fire. The maintenance director said at the time of observation, "the opening had been there forever". 3.1-19(b)	K 029	**K038 Corrective Action** All exits and sidewalks cleared on 01/31/11.	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the exit discharge for 2 of 5 emergency exits was arranged to be accessible. LSC 19.2.1 requires compliance with LSC 7.1, Means of Egress. LSC 7.1.3.2.3 requires an exit enclosure shall not be used for any purpose with the potential to interfere with its use as an exit. LSC 7.1.10.1, "Means of egress shall be continuously free of all obstructions or impediments to full instant use in case of fire or other emergency use." This deficient practice affects all visitors, staff and at least 13 residents in the F and C smoke compartments. Findings include: Based on observations with the maintenance director on 01/31/11 between 10:20 a.m. and 1:20	K 038	**Other Deficient Practice Identified** The Maintenance director and HFA shall make rounds of the facility to examine exits and sidewalks to ensure all are free of obstruction. **Systemic Changes** The maintenance director shall conduct weekly rounds ensuring all emergency exits and sidewalks are clear. **Monitoring** The maintenance director shall present the HFA with completion of rounds and results of the rounds. The maintenance director shall present completion of rounds and results to the QA Committee quarterly for review and suggestions if needed.	

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K 038	Continued From page 7 p.m., discharge paths for exit egress from the north exit in the F smoke compartment and west exit in the C smoke compartments were covered with two inches of snow. The maintenance director agreed, it had not snowed for at least two days and he had not had time to clear the pathways.	K 038	**Completion** All corrective actions completed by March 2, 2100.	
K 048 SS=C	3.1-(19) NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure the facility fire plan provided effective staff training for the protection 49 of 49 residents. This deficient practice could affect all occupants. Findings include: Based on review of the facility Fire Policy and Procedure with the maintenance director on 01/31/11 at 11:10 a.m., the document included a RACE procedure with direction after each letter listed including: "E- Extinguish if the fire is small." and directions for the use of a fire extinguisher and "If you cannot extinguish the fire, evacuate the building." There was no information regarding training of staff to determine the size of a fire. In addition, the policy did not include direction for internal evacuation from one smoke compartment to another. The maintenance director said at the time of record review, training was conducted	K 048	**K048 Corrective Action** Fire policy, fire extinguisher use updated, new internal evacuation policy implemented. **Other Deficient Practice Identified** All disaster policies reviewed by HFA. All staff to be in-serviced on new/updated policies. **Systemic Changes** HFA and maintenance director shall review all disaster/emergency policies quarterly to ensure deficient practice does not recur. **Monitoring** HFA shall present disaster/emergency policy manual to the Quality Assurance Committee. QA Committee shall review and provide suggestions if needed. **Completion**	

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K 048	Continued From page 8 annually for fire extinguisher use but no specific staff training and demonstration of determining the size of a fire was done. The evacuation of one smoke compartment to another was practiced but not specifically addressed in the written policy.	K 048	Will be completed by March 2, 2011.	
K 050 SS=F	3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: 1. Based on record review and interview, the facility failed to ensure all elements of fire drills were included on documentation of fire drills for 4 of the past 4 quarters including the date and time the drill was conducted. LSC 19.7.1.2 requires fire drills in health care facilities shall include the use of alarms, transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all occupants. Findings include: Based on a review of Fire Drill Log(s) for the past year with the maintenance director on 01/31/11 at 10:45 a.m., fire drill documentation did not include	K 050	**K050 Corrective Action** 1. Fire drill conducted shall include the actual date and time. 2. The missing fire drill has been located. **Other Deficient Practices Identified** The maintenance supervisor and HFA will review times and dates of all fire drills. **Systemic Changes** The maintenance supervisor shall provide a copy of monthly fire drills to the HFA. All copies will be included in disaster manual in the HFA office. **Date of Completion** Will be completed by March 2, 2011	

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K 050	Continued From page 9 the year each drill was conducted, the actual time of the drill, the use and transmission of the alarm and the fire conditions simulated. The time of each drill was noted as a check mark in two hour increments listed on the record. The maintenance director said at the time of record review, fire conditions were simulated, fire alarm activated and the drills done each month during 2010 but the specific information was not documented. 3.1-19(b) 3.1-51(c) 2. Based on record review and interview, the facility failed to ensure fire drills were conducted on every shift during 1 of the past 4 quarters. This deficient practice affects all occupants. Findings include: Based on a review of Fire Drill Log(s) for the past year with the maintenance director on 01/31/11 at 10:45 a.m., fire drill documentation was not found for the third shift during the second quarter of 2010. The maintenance director reviewed the records a second time and agreed the drill documentation was missing. 3.1-19(b) 3.1-51(c)	K 050		
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or	K 051	**K051 Corrective Action** 1. General Alarm contacted, will add trouble signal at the nurses station where it is likely to be heard. 2. Air deflectors shall be added to air vents to ensure smoke detectors not affected by airflow. 3. Manual fire alarm boxes will be lowered to no more than 54 inches above floor level. **Other Deficient Practice Identified**	

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K 051	Continued From page 10 extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: 1. Based on observation and interview, the facility failed to provide annunciation for 1 of 1 fire alarm systems in accordance with NFPA 72. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all occupants. Findings include: Based on observation with the maintenance director on 01/31/11 at 11:10 a.m., the automatic dialer component was disconnected to simulate trouble from phone line failure. The fire alarm control panel was located in the	K 051	The maintenance director and HFA shall examine the facility for any other violations. All violations shall be repaired. **Systemic Changes** The maintenance director shall conduct visual audits quarterly, examining for any other violations. **Monitoring** Maintenance director shall report findings of audits to Quality Assurance Committee quarterly. QA committee shall review and provide suggestions if needed. **Completion** All repairs shall be completed by March 2, 2011	

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K 051	Continued From page 11 mechanical/maintenance room. The trouble alarm could not be heard at the nurses station which is monitored 24 hours per day. The maintenance director agreed at the time of observation, an annunciator should be located at the nurses station to ensure 24 hour monitoring of the panel. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure a smoke detector connected to the fire alarm system in 3 of 6 smoke compartments were properly separated from an air supply. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect staff, visitors and 29 residents in the B, C and D smoke compartments. Findings include: Based on observations with the maintenance director on 01/31/11 between 10:20 a.m. and 1:20 p.m., smoke detectors in the following locations were located where airflow could prevent the operation of smoke detectors: a. In the corridor near room C116, four inches from an air vent; b. In the mechanical room above the fire panel, 18 inches from an exhaust fan; c. In the corridor near the C hall exit, four inches from an air vent; d. In the corridor near room D124, 31 inches from an air vent. The maintenance director said at the time of	K 051		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR NURSING CENTER	1212 E MAIN ATTICA, IN 47918

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 051	Continued From page 12 observation, the smoke detectors were originally installed in these areas. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 2 of 4 manual fire alarm boxes were located at the permitted height. NFPA 72, 2-8.1 requires the operable part of each manual fire alarm box shall be not less than 3 ½ feet (42 inches) and not more than 4 ½ feet (54 inches) above floor level. This deficient practice could affect all occupants. Findings include: Based on observations with the maintenance director on 01/31/11 between 10:20 a.m. and 1:20 p.m., manual fire alarm boxes were located higher than the maximum 54 inches allowed. The box near D124 was 63 inches above the floor and the box located near the chapel measured 60 inches above the finished floor. The maintenance director said at the time of observation, he installed new boxes at the same level they were located previously. 3.1-19(b)	K 051		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	**K052 Corrective Action** 1. New phone line added on 2/11/11 for office manager's computer to ensure the fire alarm dialer always has back-up phone line. 2. B & R contacted, new inspection of all 27 smoke detectors. **Other Deficient Practices Identified**	

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K 052	Continued From page 13	K 052		

This STANDARD is not met as evidenced by:
1. Based on observation and interview, the facility failed to provide 1 of 1 fire alarm systems with two means of transmitting a fire alarm to the monitoring station in accordance with NFPA 72. NFPA 72, 3-8.1 allows fire alarm system components to share control equipment or operate as stand alone systems, but in any case, they shall be arranged to function as a single system. NFPA 72, 5-5.3.2.1.6.1 requires a digital alarm communicator transmitter (DACT) shall be connected to two separate means of transmission at the protected premises. This deficient practice could affect all occupants.

Findings include:

Based on interview with the maintenance director on 01/31/11 at 10:55 a.m., the automatic dialer component of the fire alarm system was equipped with two phone lines to automatically transmit an alarm to the monitoring station, however, he said one line was disconnected periodically by the business office manager to facilitate a dial up computer connection for her. He said she does it for a "short time" and reconnects the fire alarm dialer when her work is done. He said he did not monitor how often this occurs and could not be specific about the times the dialer was off line for the phone line she used. The business manager was interviewed 01/31/11 at 11:05 a.m. at the fire alarm control panel, and demonstrated how she

The maintenance director and HFA shall review all inspection reports to ensure no other discrepancies. All discrepancy noted shall have new inspection requested.

Systemic Changes
The maintenance director shall conduct quarterly review of all inspections. Quarterly audits will ensure deficient practice does not recur.

Monitoring
Maintenance director shall report any review findings to Quality Assurance Committee, QA committee shall review and provide suggestions if needed.

Completion
All inspections shall be completed by March 2, 2011.

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K 052	Continued From page 14 unplugged one phone line from the fire alarm system and plugged it into another connection to allow her PC to operate. She said she had to silence a trouble alarm on the fire alarm control panel (FACP) each time the phone line was disconnected. The maintenance director confirmed at 11:15 a.m. on 01/31/11, the FACP would sound a trouble when the line was disconnected. He agreed the FACP was left without the required second phone line each time the disconnection was made. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure documentation for the annual testing of 1 of 1 fire alarm systems components and devices such as smoke detectors, heat sensors and fire alarm pull stations was complete. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors, heat sensors, fire alarm pull stations, and fire alarm control equipment be tested annually. The inspection should include locations and serial numbers, the test/inspection done and whether each device passed or failed. This deficient practice could affect all occupants. Findings include: Based on review of the facility's Smoke Detector Test Report(s) for the annual inspection and function test with the maintenance director on 01/31/11 at 11:00 a.m., a discrepancy existed in the number of smoke detectors tested. Two different contractors did testing of the smoke detectors. One company report dated 12/15/10 listed 27 smoke detectors. A second company, whose testing included a sensitivity test dated	K 052		

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K 052	Continued From page 15 03/08/10 listed 25 smoke detectors. The detector locations for each report were tracked differently so a comparison of the documentation could not determine what smoke detectors, if any, were omitted in testing. The maintenance director said at the time of record review, he did not know the exact number of smoke detectors in the facility, had not noted the discrepancy, and no detectors had been added or removed. 3-1.19(b)	K 052		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the supply of spare sprinkler heads for 1 of 3 types used in the facility as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2-4.1.4 requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. A minimum of two sprinklers of each type and temperature rating installed shall be provided. NFPA 25, 2-2.1.3 requires an annual inspection of the spare sprinkler supply for the proper number and type. This deficient practice could affect 4 occupants in the kitchen. Findings include:	K 062	**K062 Corrective Action** Spare sprinkler heads ordered from Safe Care. **Other Deficient Practices Identified** The maintenance director and HFA shall examine container of spare sprinkler heads, to ensure there are no other missing sprinkler heads. **Systemic Changes** The maintenance director shall conduct a quarterly visual review of storage container of spare sprinkler head. Audit will ensure deficient practice does not recur. **Monitoring** Maintenance director shall report any review findings to Quality Assurance Committee. QA committee shall review findings and provide suggestions if needed. **Completion** Shall be completed by March 2, 2011.	

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K 062	Continued From page 16 Based on observation of the supply of spare sprinkler heads with the maintenance director on 01/31/11 at 1:15 p.m., no pendant heads of the type used in the kitchen were found. The maintenance director said at the time of record review, the sprinkler contractor "would bring them" if needed. 3.1-19(b)	K 062	**K143 Corrective Action** Door replaced with new fire rated door and installed with self-closure, mechanical vent installed, vinyl tile removed from floor and sign posted indicating storage and transfer of oxygen occur in this room. **Other Deficient Practice Identified** The maintenance director and HFA shall examine the oxygen storage and transfer room, after all work has been complete. If any other issues noted, they shall be fixed at that time. **Systemic Change** The maintenance director shall conduct quarterly visual audits to ensure deficient practice does not recur. **Monitoring** The maintenance director shall report any audit findings to Quality Assurance Committee. QA committee shall review and provide suggestions if needed. **Monitoring** All repairs shall be completed by March 2, 2011.	
K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms where transfilling occurs was separated from resident areas by a fire rated door in the one hour	K 143		

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K 143	Continued From page 17 enclosure, provided with mechanical ventilation, and a ceramic tile or concrete floor, and posted with a sign to alert occupants oxygen transferring is taking place therein. This deficient practice affects visitors, staff and more than 4 residents in the B smoke compartment. Findings include: Based on observation with the maintenance director on 01/31/11 at 12:45 p.m., the oxygen supply storage room was identified by the maintenance director as the site used to fill portable oxygen supply tanks. The solid core door had no fire rating or self closer. There was no mechanical ventilation, no sign to indicate the storage and transfer of oxygen occur in the room, and the floor was covered with vinyl tile. The maintenance director said he had waited for inspection to determine if all the criteria was met for the room recently designated for oxygen transfer.	K 143	**K147 Corrective Actions** All outlets in bathrooms will be replaced with GFCI protected receptacles. **Other Deficient Practices Identified** The maintenance director and HFA shall examine facility for any other outlets located within 24 inches of sinks. Any outlets; with in 24 inches of sinks will be replaced. **Systemic Changes** The maintenance director shall conduct quarterly visual audits	
K 147 SS=F	3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure wet locations for 27 of 27 resident rooms were provided with GFCI (ground-fault circuit interrupter) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subject to wet conditions while patients are	K 147		

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K 147	Continued From page 18 present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice affects all residents. Findings include: Based on observations with the maintenance director on 01/31/11 between 10:20 a.m. and 1:20 p.m., electrical outlets in all resident room bath rooms were located 24 inches from sinks. The outlets were not provided with GFCI (ground fault circuit interrupter) protection to prevent electric shock. The maintenance director checked electrical panels for GFCI circuit breakers at the time of observation. He said no GFCI circuit breakers were found. 3.1-19(b)	K 147	examining for any outlets within 24 inches of water source that are not GFCI outlets. Any outlets shall be replaced. **Monitoring** Maintenance director shall report any audit findings to Quality Assurance Committee. QA committee shall review and provide suggestions if needed. **Completion** All outlets within 24 inches of water source shall be replaced by March 2, 2011.	
K 211 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source.	K 211	**K211 Corrective Action** The alcohol based hand sanitizer located above electrical light switch moved on 1/31/11. **Other Deficient Practice Identified** The maintenance director shall conduct facility audit to ensure all alcohol based hand sanitizers are placed in area that is in compliance	

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K 211	Continued From page 19 o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure alcohol based hand sanitizers in 1 of 2 exit corridors were not installed over an ignition source. NFPA 101 in 19.1.1.3 requires all health facilities to be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects visitors, staff and an undetermined number of residents in the F smoke compartment where the main dining room is located. Findings include: Based on observation with the maintenance director on 01/31/11 at 1:55 p.m., an alcohol based hand sanitizer (ABHS) dispenser was located above the electrical light switches in the corridor outside the kitchen service window. The maintenance director said at the time of observation, he "missed" removing the ABHS dispenser from above the light switch. 3.1-19(b)	K 211	with NFPA 101, IN 19.1.1.3. If noncompliance noted the alcohol based hand sanitizer shall be removed. **Systemic Changes** Reinstallment of alcohol based hand sanitizers shall be completed in areas that are in compliance with NFPA 101, IN 19.1.1.3. **Monitoring** The maintenance director shall conduct monthly rounds to ensure no further installment of alcohol based hand sanitizers in areas over an ignition source. The maintenance director shall report results of rounds to HFA ands QA committee on quarterly basis for review and possible suggestions. **Completion** All corrections will complete by March 2, 2011.	